Guidelines for writing guidelines

Last year I expressed my concern in the letter "Clinical practice guidelines" (*Can Med Assoc J* 1993; 148: 1450) that the clinical practice guidelines[1-3] published by *CMAJ* were written in such turgid English that guidelines to interpret them might be needed.

My fears are confirmed with the CMA's *Guidelines for Canadian Clinical Practice Guidelines,* which accompanied the Mar. 15 issue of *CMAJ.*

Alas, this recent effort is no better than the guidelines I criticized. It uses such impenetrable English that probably no more than 1% of its intended readers will bother to wade through it. The authors' unfortunate addiction to the use of footnotes is distracting, and the footnotes are pompous and unhelpful.

For example, guideline 12 states (with the footnotes included after the footnote symbol) that "the clinical practice guideline process should include tailored, effective and coordinated strategies for voluntary* (*Permit a physician to exercise appropriate clinical judgement based on the characteristics of the patient and setting.) implementation† (†Dissemination and adoption of clinical practice guidelines.) that emphasize patient,‡ (‡Can include patient advocates such as family, friends and other health care providers.) physician and other health care provider involvement."

Surely we can do better than this gibberish. To me the authors of this effort are so worried about hurting practitioners' feelings that they can't call a spade a spade. If the guidelines are intended to improve quality of health care (and reduce costs) why not simply say, for example, that far too many imaging studies are ordered to investigate backache and give examples of how this increases health care costs and radiation exposure, causes unnecessary concern to patients and sometimes leads to inappropriate surgery?

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References

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2. Naylor CD, Williams JI, Basinski A et al: Technology assessment and cost-effectiveness analysis: Misguided guidelines? *Can Med Assoc J* 1993; 148: 921–924
3. Laupacis A, Feeny D, Feeny D et al: Tentative guidelines for using clinical and economic evaluations revisited" *Can Med Assoc J* 1993; 148: 927–929

We seem to be spending more time these days preparing mission and goal statements and quality of care guidelines or programs than actually providing patients with quality health care. Now, to top it all, we have been sent the CMA's *Guidelines for Canadian Clinical Practice Guidelines.*

What next? *Guidelines for Guidelines for Canadian Clinical Practice Guidelines* and so on *ad infinitum*? This issue seems like a make-work project for administrators and bureaucrats.

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[The CMA responds:]

Clinical practice guidelines can be useful and essential tools but only if they are properly prepared. With many groups creating guidelines for the first time, there was a call for leadership from the CMA to develop a set of principles on guidelines. In addition, because many CMA members were just beginning to use guidelines, we recognized the need to help them judge a guideline. For these reasons we wrote the guidelines for guidelines.

A 2-year process of broad consensus development, involving nearly 50 organizations (including voluntary medical and other professional bodies, government and licensing authorities), resulted in a precedent-setting consensus.

We tried to keep the wording of the guidelines simple so that the main concepts were clear. The words, however, needed definition and expansion to achieve consensus. We used footnotes for this rather than make the concepts complex. We regret that Dr. Harris found this effort to achieve simplicity and clarity "impenetrable." In fact, we did call a spade a spade and came right out and

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